Washington State DEPARTMENT OF SOCIAL & HEALTH SERVICES

MEDICAL COVERAGE INFORMATION

COMMUNITY SERVICES OFFICE (CSO)	CSO TELEPHONE NUMBER
CLIENT NAME	CLIENT TELEPHONE NUMBER
CASE NUMBER	DATE

COOPERATION

☐ 1. OSE referral: YES NO
a. Required? ☐ ☐
b. Made? ☐ ☐
☐ 2. OSE/TPL/Good Cause established? ☐ ☐

INSTRUCTIONS: The purpose of this form is to help us determine whether there is any other medial coverage available for your medical costs. Please print your answers. Answer each question as completely as you can for yourself or for other persons you are applying for. We may ask you to verify your answers. If you need help completing this form or if your coverage changes call **1-800-562-6136**.

A. Do you have Medicare? ☐ Yes ☐ No

IF YES, NAME OF PERSON WITH MEDICARE | MEDICARE CLAIM NUMBER

B. Do you have health insurance coverage? ☐ Yes ☐ No
This includes any insurance you, or someone else pays for, such as private insurance, school insurance, group insurance from your employer, etc. If yes, complete the following.

POLICY NUMBER 1	POLICY NUMBER 2
INSURANCE COMPANY NAME	INSURANCE COMPANY NAME
INSURANCE COMPANY ADDRESS	INSURANCE COMPANY ADDRESS
GROUP AND/OR POLICY NUMBERS	GROUP AND/OR POLICY NUMBERS
CONTRACT, CERTIFICATE, AND/OR ENROLLMENT NUMBERS	CONTRACT, CERTIFICATE, AND/OR ENROLLMENT NUMBERS
POLICY BEGINNING DATE / POLICY ENDING DATE	POLICY BEGINNING DATE / POLICY ENDING DATE

List who is covered by this policy:

NAME	SOCIAL SECURITY NUMBER	BIRTHDATE

List who is covered by this policy:

NAME	SOCIAL SECURITY NUMBER	BIRTHDATE

Check the services your policy covers:

- ☐ In-patient hospital care
- ☐ Out-patient hospital care
- ☐ Prescription drugs/supplies
- ☐ Eye glasses/vision care
- ☐ Other (ambulance, therapy, chiropractic, etc.)
- ☐ Nursing home care
- ☐ Dental care
- ☐ Physician services

Check the services your policy covers:

- ☐ In-patient hospital care
- ☐ Out-patient hospital care
- ☐ Prescription drugs/supplies
- ☐ Eye glasses/vision care
- ☐ Other (ambulance, therapy, chiropractic, etc.)
- ☐ Nursing home care
- ☐ Dental care
- ☐ Physician services

C. Is there at least one child in your home whose parent is absent or is there an unborn for whom an absent parent is responsible?
☐ Yes ☐ No If yes, complete the following information about each absent parent.

NAME, ADDRESS, AND TELEPHONE NUMBER	SOCIAL SECURITY NUMBER	CHILD(REN) NAME	COURT ORDER FOR MEDICAL COVERAGE
			☐ Yes ☐ No
			☐ Yes ☐ No

D. Do you have CHAMPUS (military) coverage available? ☐ Yes ☐ No

IF YES, MEMBER'S NAME | MEMBER'S SOCIAL SECURITY NUMBER

E. Are any of the following persons working and/or members of a union? Complete the following.

#	PERSON WORKING/ UNION MEMBER	YES	NO	IF YES, LIST NAME AND ADDRESS	LOCAL NUMBER	HEALTH INSURANCE AVAILABLE YES	NO
1	You or your spouse						
2	Your minor child(ren)						
3	Minor's natural parent(s)						
4	Minor's absent parent(s)						
5	Absent parent(s)						

MEDICAL COVERAGE INFORMATION, Page 2

COMMUNITY SERVICES OFFICE (CSO)	CASE NUMBER

Please complete the following for any person listed on Page 1 in Section E. that you have checked with a YES answer.

PERSON NUMBER	EMPLOYER'S NAME/ADDRESS/TELEPHONE NUMBER	UNION NAME

F. After April 7, 1987, did you or your spouse have medical insurance through employment? ☐ Yes ☐ No
If your answer is yes AND you no longer work for that employer, complete the following:

1. Name of your insurance company: _____
2. Beginning date of insurance coverage: _____ Ending date of insurance coverage: _____
3. When did the employment end? Date: _____
4. Did the insurance company notify you that you could continue your coverage? ☐ Yes ☐ No
   If yes, when did they notify you? Date: _____
5. List the name, address, and phone number of that employer:

G. Does your employer or your spouse's employer offer medical insurance that you do not take because you would have to pay for it?
☐ Yes ☐ No If yes, list name, address and telephone number of employer:

H. Have you or the person you are applying for had an accident requiring medical care? ☐ Yes ☐ No
If yes, answer the following:

1. DATE OF ACCIDENT	2. CHECK WHERE THE ACCIDENT HAPPENED
	☐ Automobile ☐ School ☐ Store/business ☐ Home ☐ Other person(s) home/property ☐ Place of employment ☐ Other:

a. Address of accident (street, city, and state): _____
b. Check if the patient was the ☐ driver; ☐ passenger; ☐ pedestrian.
c. Were other automobiles involved? ☐ Yes ☐ No If yes, list name and address of other drivers:

3. Name(s) of person(s) hurt in the accident:

NAME	TYPE OF INJURY

4. How did the accident happen?

5. Is an insurance company involved? ☐ Yes ☐ No If yes, give the name of the insured: _____
Name/address of insurance company:

CLAIM NUMBER	POLICY NUMBER	ADJUSTER NAME	TELEPHONE NUMBER

6. Did you file another claim for the accident? ☐ Yes ☐ No If yes, give the claim number(s).

LABOR AND INDUSTRIES CLAIM NUMBER	SELF INSURED CLAIM NUMBER	VICTIM OF A VIOLENT CRIME CLAIM NUMBER	OTHER

7. Is a lawyer involved? ☐ Yes ☐ No If yes, give name, address, and telephone number:

8. What financial/medical benefits did you receive or do you expect to receive because of your injury? Explain: